**CYP Outreach Service Referral Form**

**Please read the following guidance.**

By completing this referral form, you’re helping us to make contact safely and quickly. Please ensure that you include as much information as possible - this saves the family being asked the same questions twice and helps us to understand more about their particular needs and circumstances.

**How to submit this referral:**

Please submit this referral by emailing it to childsupport@swindonwomensaid.org.

We will acknowledge receipt of the referral within 24hrs. We will make initial contact with the family within 3 working days following receipt of the referral.

***Essential criteria when referring into this service:***

|  |  |
| --- | --- |
|  | **Please tick** |
| *CYP who have an awareness/understanding of, or who have experienced/witnessed domestic abuse within their home or the wider family.* |  |
| *CYP ages 7 – 17yrs, living in the Swindon area.* |  |
| *CYP not currently living with a perpetrator of domestic abuse**.* |  |
| *CYP who are willing to engage in 1 to 1 support sessions with a regular outreach support worker.* |  |
| *CYP displaying signs of emotional & behavioural issues as a direct result of exposure to domestic abuse.* |  |
| *Consent from the non-abusive parent/carer must be sought prior to referral.* |  |

***Please also consider the following:***

* *Are there any risks to working with this CYP? E.g., risk of escalation from the perpetrator of the domestic abuse.*
* *Is the CYP already engaged in other interventions of a similar nature?*

**How to get in touch:**

If you have any questions about our service, eligibility criteria, or how to make a referral, please contact:

Swindon Women’s Aid 24hr Helpline 01793 610610

SWA Children’s and Young People’s Outreach Support Worker – Katie Woolhouse

SWA Children & Young People’s Outreach Service Manager – Charlotte Gibbon

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| --- |
| 1. **Information about the person making the referral**
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|  |
| Date of referral: |  |
| **Please indicate which service you’d like to refer to:** |
| CYP Outreach Support |
| **Please enter your name and contact details:**  |
| Referrer’s name |  |
| Organisation name |  |
| Role/ job title |  |
| Contact number  |  |
| Contact email |  |

1. **CYP contact info.**

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| --- |
| **CYP Details** |
| First name |  |
| Last name |  |
| Other names |  |
| What do they like to be called? |  |
| DOB |  |
| Current Age |  |
| **Parent/Guardian Details** |
| Name of Parent/Guardian: |  |
| *Is it safe to directly contact this parent/carer? Yes No (please highlight)* |
| Phone Number |  |
| Email Address |  |
| Current Home Address |  |
| Safe contact notes  |  |
| **EMERGENCY CONTACT INFO** **Next of kin if different to the parent/guardian** |
| Name  |  | Relationship |  |
| Contact information  |  |
| Safe contact notes |  |
| **School/College info:** |
| Which school/college does the CYP attend? |  |
| If there is a pastoral worker or someone who is working with the family that is already aware and supporting this CYP, please tell us their name AND contact details if possible |  |
| **Safeguarding**  |
| Are children’s services involved in this case? | Yes [ ]  No[ ]  Don’t Know [ ]  |
| Level/ nature of involvement – notes: (If the CYP has a social worker, please give us their name) |  |
| **Accessibility requirements**  |
| Does this CYP have any accessibility requirements (for example, hearing loop, braille documents) | Yes [ ]  No[ ]  Don’t Know [ ]  | *If yes, please provide details:* |
| Do they have any allergies? | Yes [ ]  No[ ]  Don’t Know [ ]  | *If yes, please provide details:* |
| Does this CYP require an interpreter? | Yes [ ]  No[ ]  Don’t Know [ ]  | *If yes, please provide details:* |

1. **Client Equalities Monitoring**

|  |  |
| --- | --- |
| How would this client describe their gender? | Female [ ] Male [ ] Other *(please specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*Don’t Know [ ]  |
| Is their current gender **different** to the sex they were assigned at birth? | Yes [ ] No [ ]  Don’t know [ ]  |
| Do they consider themselves to have any kind of disability? (please tick any that apply) |  Physical [ ]   Learning [ ] Mental Health [ ] Deaf/ hearing impaired [ ] Blind/ visually impaired [ ] Other *(please specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*Don’t Know [ ]  |
| How would they describe their ethnicity? |
| White British [ ]  White Irish [ ] White Gypsy or Irish Traveller [ ] Any other White background [ ] Asian British [ ] Asian Indian [ ] Asian Pakistani [ ] Asian Bangladeshi [ ] Any other Asian background [ ] Chinese [ ]  Arab [ ]  | White and Black Caribbean [ ] White and Black African [ ] White and Asian [ ] Any other mixed/ multiple background [ ] Black British [ ] Black African [ ] Black Caribbean [ ] Any other Black background [ ] Other *(please specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*Don’t Know [ ]  |
| Do they have a faith/ religion?  |
| No religion [ ] Bahai [ ]  Buddhist [ ] Christian [ ] Hindu [ ] Jewish [ ] Jain [ ]  | Muslim [ ]  Shinto [ ]  Sikh [ ] Zoroastrian [ ]  Other *(please specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*Don’t Know [ ]  |
| If appropriate, what is their sexual orientation? | Heterosexual [ ] Gay woman [ ] Gay man [ ] Bisexual [ ] Other *(please specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*N/A [ ]  |

1. **CYP Support Needs/ Vulnerabilities**

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| --- |
| **Please tell us more about any support needs the client may have:** |
| Mental Health [ ] Physical Health [ ] Sexual Health [ ]  Substance misuse [ ] Aggressive behaviour [ ]  Self-harming/ suicidal feelings [ ]    | Educational attainment/ attendance [ ]  Social isolation [ ] Bullying/ being bullied [ ]  Experiencing abuse [ ] Other *(please specify below)*  |
| **Additional details:** |
|  |

1. **Siblings**

|  |
| --- |
| **Please provide names and DOBs for any siblings below:** |
| Name | DOB |
|  |  |

1. **Reason for Referral**

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| --- |
| **It is important that this section is completed in detail. Please consider these questions when completing this section:***What has been going on?**How long has this been going on for?**Can you tell me who is involved?**Is the CYP having contact with the perpetrator of the domestic abuse? If so, please tell us more about that.**Tell us more about the behaviours, fears, worries or anxieties of the CYP.**How do you think SWA could help?* |
|  |
| **Are there any known risks to working with this child?**  |
|  |
| **Please tell us about any other support this CYP is receiving and when this due to end, e.g., STEP, Seeking Solutions, CAMHS/TAMHS, ELSA etc** |
|  |
| **Has the parent/guardian of the CYP consented to this referral** |
|  |

Thanks for taking the time to complete this referral.

To submit your fully completed document, please email childsupport@swindonwomensaid.org

**Before you send the referral, please ensure that your referral meets the criteria set out on the first page of this document.**

Please attach any other relevant documents that would support this referral.